Opponents of this proposal would argue that the reduced level of federal support for these programs would strain state budgets if current services were maintained. In response, these jurisdictions might restrict eligibility or reduce benefits in their Medicaid and AFDC programs. Another possible argument against the option is that per capita income is not a good measure of the relative ability of states to pay the costs of welfare programs, and therefore penalizing those states benefiting from the 50 percent minimum federal share in the Medicaid formula would be unfair.

ADDED STATE FLEXIBILITY IN SETTING MEDICAID REIMBURSEMENT RATES

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	250	280	320	350	390	1,590
Outlays	250	280	320	350	390	1,590

NOTE: Preliminary estimates, subject to change.

The federal government significantly limits the ability of states to bargain with hospitals when establishing the level of payment for Medicaid patients. Unless specific approval is obtained from the Department of Health and Human Services, each state must reimburse hospitals for the average cost of treating Medicaid patients. Since the federal government pays at least 50 percent of state expenditures for medical care under Medicaid, the level of hospital reimbursement in each state directly affects federal outlays.

If the states were permitted more flexibility, they might be able to set hospital reimbursement rates at levels lower than average costs but high enough to be acceptable to a sufficient number of hospitals to serve the needs of Medicaid patients. States could also more easily include Medicaid hospital reimbursement in statewide hospital rate-setting programs.

Proponents of this option argue that it could induce hospitals to cut their costs in response to this market-like constraint. They also argue that hospitals might prove willing to accept Medicaid patients at less than average cost, so long as they were reimbursed for the incremental cost of each Medicaid patient. If the Medicaid program were withdrawn, hospitals would receive little or no reimbursement for such patients.

Opponents of the proposal point out that, if hospitals received less than their average costs for Medicaid patients, they might not cut costs but simply raise charges to other patients. Moreover, some hospitals could refuse to accept Medicaid patients, thus

reducing access to health care by the poor. (Others argue that hospitals' abilities to take such actions are limited.)

The estimate given above is illustrative and assumes a 5 percent reduction in Medicaid hospital reimbursements. The suggested savings of $1.6 billion in 1982-1986 are subject to considerable uncertainty because the effectiveness of the proposal would depend on the extent to which state Medicaid agencies reduced hospital reimbursement rates.

INCENTIVES TO STATES FOR HOSPITAL COST CONTAINMENT

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	0	50	100	200	350	700
Outlays	0	100	400	800	1,100	2,400

NOTE: Preliminary estimates, subject to change.

Hospital costs have been rising rapidly for some time, averaging 15 percent a year from 1968 to 1979. These increases have contributed to the substantial growth in federal outlays for Medicare and Medicaid. The Carter Administration twice proposed to the Congress federal limits on increases in hospital revenues per admission, but neither proposal passed.

About eight states currently set maximum rates for hospital charges. Although the programs differ substantially from state to state, recent studies show that as a group they have been effective at restraining increases in hospital costs. The federal government, through financial incentives, could encourage additional states to adopt rate-setting programs. This could reduce not only federal and state outlays, but payments by private purchasers of hospital care.

One proposal would have the federal government share with the states some of the savings to Medicare that are attributable to state efforts in this area. Currently, states with effective rate-setting programs cut their outlays by only 11 cents (principally the state share of Medicaid) for every dollar that Medicare and Medicaid outlays are reduced. Allowing states to keep a higher share of these savings might induce additional states to initiate effective rate-setting efforts. Such incentives could be augmented by automatically granting waivers for alternative Medicare and Medicaid reimbursement policies to states participating in the program.

The major argument in favor of encouraging state rate-setting is that extensive third-party financing of hospital care (by

government agencies and private insurers) has eliminated the normal market restraints on hospital spending, leaving regulation as the only practical alternative. State-level limits on hospital revenues might be more effective than federal limits because of additional flexibility, the ability to tailor programs to local conditions, and opportunities for states to attempt a variety of approaches and learn from each other's experiences. Indeed, the House of Representatives, in amending the Carter Administration's hospital cost containment proposal so as to remove federal revenue limits, sought to encourage state-level programs (H.R. 2626, Hospital Cost Containment and Reporting Act of 1979).

The major argument against state rate-setting is that it is a regulatory approach. Although it has been effective at cutting costs thus far, there is no certainty that this success will continue or that it may not have been at the expense of quality of care and efficiency.

Savings to the federal government under this proposal would depend upon the number and size of states initiating rate-setting programs, the effectiveness of the program, and the details of the incentive formula. The estimate presented above, of $2.4 billion in savings over five years, is based on assumptions that states accounting for 25 percent of hospital expenditures would implement programs in response to the proposal and that one-third of the Medicare savings would be returned to the states. Savings could be higher or lower, and could even be negative if few states initiated programs and those states that currently have programs were rewarded for continuation of their past efforts as well as for increased activity.

ELIMINATION OF MERCHANT SEAMEN HEALTH CARE ENTITLEMENT

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline						
BA	80	130	150	160	180	700
Outlays	75	130	140	155	165	665
Carter Budget						
BA	70	N.A.	N.A.	N.A.	N.A.	N.A.
Outlays	60	N.A.	N.A.	N.A.	N.A.	N.A.

NOTE: Preliminary estimates, subject to change.

American merchant seamen have been entitled since 1798 to free, all-inclusive health care from the federal government. That care is now provided in 8 hospitals and 27 clinics operated by the Public Health Service (PHS). If the entitlement were ended beginning fiscal year 1982 and the PHS facilities were disposed of, the five-year savings would be about $665 million.

The argument for ending this entitlement is that it is no longer necessary. It grew out of 18th-century circumstances, when seamen had high rates of communicable diseases that posed a danger to public health, and when health care facilities in ports were primitive. Improved health, the declining size of the merchant fleet, and the growth of collectively bargained health care plans have led to low demands by seamen on the PHS system, some of which needs extensive modernization.

Only one-third of PHS users are seamen, accounting for about 14,000 inpatient admissions and 600,000 outpatient visits in 1980. The system has sought to avoid severe underutilization by providing services, on a reimbursable basis from other government agencies, to military personnel and their dependents and to the beneficiaries of Community Health Services programs. Even so, PHS hospitals have more excess capacity than is the norm in private hospitals.

The argument against ending the entitlement and closing the PHS facilities is that many seamen would, at least in the short run, have to find and pay for their own health insurance coverage. Also, the facilities are providing useful services to

military personnel and other persons. Many of the PHS facilities are located in medically underserved neighborhoods, and their closing could mean reduced access to care for some low-income persons.

If the hospitals were closed without ending the entitlement, the savings would be much lower than shown above. Keeping the entitlement would require that federal health insurance benefits be provided for all seamen, even those currently receiving medical care outside the PHS system.

President Carter's budget recommendations for fiscal year 1982 do not contain sufficient detail for years after 1982 to calculate the savings this proposal would achieve in those years, relative to his budget.

TERMINATION OF SOME FEDERAL MEDICAID FUNDING

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	320	350	390	440	490	1,990
Outlays	320	350	390	440	490	1,990

NOTE: Preliminary estimates, subject to change.

People eligible for Supplemental Security Income (SSI), a federal income support program for the needy aged, blind, and disabled, generally qualify automatically for Medicaid, the federal-state health care program for the poor. Thirty-eight states provide supplemental SSI benefits to some aged, blind, and disabled persons whose income disqualifies them for federal SSI payments. Thirty-four of these states have chosen to provide Medicaid to recipients of such supplemental payments, and the federal government pays a minimum of 50 percent of the Medicaid expenditures that result from their participation.

If the federal government were to cease paying any part of the Medicaid costs for recipients of these supplemental payments, the five-year savings through fiscal year 1986 could be almost $2 billion.

This change would eliminate or reduce Medicaid benefits for about 600,000 persons. Those living in states with coverage for the medically needy could continue to receive some benefits, however.

Supporters argue that those affected by the change are among the least needy persons eligible for Medicaid. Further, such a change would lead to more equal nationwide treatment by the federal government in its income support programs for the needy aged, blind, and disabled.

On the other hand, most of the people disqualified under this proposal have low incomes, even though not eligible for SSI. Furthermore, federal policy in many welfare programs has been to

encourage states to extend eligibility beyond minimal levels. As an incentive, the federal government has agreed to finance part of the cost of including additional categories of persons or enriching benefits in some income support programs. Interstate variations result from this policy and, if accepted in programs such as Aid to Families with Dependent Children (AFDC), should be acceptable in Medicaid as well.

TIGHTENING OF THE MEDICAL EXPENSE DEDUCTION

	Annual Revenue Effect (billions of dollars)					Cumulative Five-Year Increase
	1982	1983	1984	1985	1986	
Loss under Current Law	4.1	4.7	5.3	6.0	6.9	
Increase from Eliminating Health Insurance Deduction	0.4	0.4	0.5	0.6	0.7	2.6
Increase from Raising Floor for Deductible Expenses to 10 Percent of AGI	2.2	2.5	2.8	3.2	3.7	14.3
Increase under Carter Budget	(no proposal)					

NOTE: Preliminary estimates, subject to change.

The 35 percent of taxpayers who itemize may claim as deductions up to $150 for health insurance premiums, plus all out-of-pocket medical expenses that in total exceed 3 percent of adjusted gross income (AGI).

The separate deduction for health insurance premiums was adopted in 1965, in the belief that it would encourage the purchase of such insurance. There is no empirical evidence that it has had such effects. But there is substantial evidence that the financial assistance provided by this tax subsidy is not well targeted on those with the greatest need. The deduction is claimed by less than 4 percent of all taxpayers with incomes under $10,000, but by more than 50 percent of those with incomes over $100,000.

The deductibility of medical expenses above 3 percent of adjusted gross income has been justified on the ground that it assists people with extraordinary and involuntary expenses. But some of those expenses are optional rather than involuntary. The deduction has also been criticized for the characteristic it shares with all deductions: it provides a larger, rather than a smaller, subsidy rate the higher a person's income.

The basic argument for change in this instance is that, if the income tax system is to be used to shift part of a person's health

care costs to the federal treasury, the relief ought to be confined to taxpayers with genuine financial need. This is the same principle that governs Medicaid, the government's direct expenditure health care program for the poor. By this standard, the separate deduction for health insurance premiums would be repealed, and the 3 percent threshold for the medical expense deduction raised to a level considerably higher than the average family health care cost burden.

Repeal of the deduction for health insurance premiums would increase federal revenues by about $2.6 billion over the 1982-1986 period. If the threshold for the medical expense deduction was raised to 10 percent effective January 1, 1981, revenues for the five-year period would increase by about another $14.3 billion.

TAXATION OF SOME EMPLOYER-PAID HEALTH INSURANCE

	Annual Revenue Effect (billions of dollars)					Cumulative Five-Year Increase
	1982	1983	1984	1985	1986	
Loss under Current Law	21.4	25.3	29.8	35.1	41.4	
Increase from Limiting the Exclusion	1.9	2.5	3.3	4.4	5.9	17.9
Increase under Carter Budget	(no proposal)					

NOTE: Preliminary estimates, subject to change.

Employees do not pay taxes on income received in the form of employer-paid health care coverage. This exclusion will reduce income tax revenues by about $21 billion in fiscal year 1982, somewhat more than total federal spending on Medicaid, the major program financing health care services for the poor. This form of income also escapes payroll taxation, reducing Social Security trust fund revenues by about $7 billion in 1982.

One proposal for limiting the present exclusion would restrict tax-free employer contributions to $120 a month for family coverage in 1981, with the amount to be adjusted to inflation in the future. This is similar to the approach already adopted by the Congress in connection with employer-provided group life insurance. The proposal would raise income tax revenues by $1.9 billion and payroll tax revenues by $0.7 billion in fiscal year 1982. Over five years, the revenue increases would amount to $17.9 billion and $7.0 billion, respectively. In 1982, such a limitation would affect about 23 million employed persons--roughly one-third of those who participate in employer-sponsored health insurance plans. Similar proposals were introduced in the 96th Congress but did not come to a vote.

Both health policy and tax policy arguments have been made for limiting this exclusion. The exclusion leads to what many consider to be overly extensive health insurance coverage, which has expanded use of health care services and, consequently, driven up their prices. The provision disproportionately benefits persons with higher incomes, because they tend to have larger employer-paid

health insurance premiums that are excluded from taxation and because they are in higher marginal tax brackets.

Opponents of such a measure argue that present health insurance coverage is not excessive and that reductions in insurance coverage might cause some people to forgo important medical care. Also, they argue that a $120 per month ceiling would have uneven effects, for that amount purchases differing levels of coverage depending on several factors, such as geographic location and the composition of the work force.

LIMITING OF HOSPITAL BOND TAX EXEMPTION

	Annual Revenue Effect (billions of dollars)					Cumulative Five-Year Increase
	1982	1983	1984	1985	1986	
Loss under Current Law	0.7	0.8	0.9	1.0	1.2	
Increase from Repeal of Tax Exemption on New Bonds	0.1	0.2	0.3	0.5	0.6	1.8
Increase under Carter Budget	0.1	0.2	0.4	0.5	0.7	1.9

NOTE: Preliminary estimates, subject to change.

About half the funding for capital projects at hospitals comes from tax-exempt bonds. Over $3.4 billion of these bonds were issued in 1979 alone. More than 75 percent were used to finance private nonprofit hospital projects, with the rest supporting public government-owned hospitals. The federal revenue loss in fiscal year 1982 from all outstanding private hospital bonds will be about $700 million.

The lower borrowing costs from tax-exempt bond financing provide savings to the hospital, which they may pass on in the form of lower charges to patients, to insurers, and to the federal government though Medicare and Medicaid. These potential cost savings are outweighed, however, by the revenue losses from the bonds. As with all tax-exempt bond subsidies, about a quarter of the subsidy goes to outsiders including bondholders, underwriters, and bond counsel. Every $1 saved by the borrowing hospitals thus costs $1.33 in lost federal revenue.

The effectiveness of the subsidy can also be questioned because it allocates resources on the basis of a hospital's financial standing, rather than on the need for such facilities in a particular area. At present, the United States does not have a general shortage of hospital beds, and thus the Congress has sharply reduced direct expenditure subsidies for hospital facilities.

Eliminating the tax exemption for private hospital bonds issued after July 1, 1981, would increase fiscal year 1982 revenues by about $100 million, and the amount would grow significantly in later years, reaching about $600 million by fiscal year 1986. The Carter budget contains a similar ban on further tax-exempt bond financing by private hospitals, effective January 1, 1981, but extends it to all tax-exempt private institutions, including colleges and universities. Both of these options would preserve tax-exempt financing for public hospitals.

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TERMINATION OF CERTAIN SOCIAL SECURITY BENEFITS

Phasing Out Postsecondary Student Benefits. Both the Ford and the Carter Administrations recommended phasing out Social Security postsecondary student benefits, which are paid to unmarried full-time students between 18 and 22 who are dependents of retired, deceased, or disabled workers. Child dependent benefits otherwise stop at age 18.

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	-24	-96	-216	-391	-612	-1,339
Outlays	650	1,235	1,820	2,480	2,710	8,895

NOTE: Preliminary estimates, subject to change.

This entitlement was added to the Social Security system in 1965. Since that time, the Congress has greatly expanded other forms of student assistance. Thus, it can be argued that phasing out these Social Security student benefits would eliminate some duplicative payments; other federal student aid programs would ensure that those in need would not be denied access to higher education for financial reasons.

The argument against this reduction in Social Security benefits is that the vast majority of full-time students are still financially dependent upon their families. Therefore, the dependency notion behind the Social Security system's benefits would suggest that continued payments are warranted.

If no new student beneficiaries were added after July 1981, and if those already receiving benefits were phased out over the next three years, federal savings would amount to nearly $8.9 billion in the 1982-1986 period. These savings would be partially offset by increases in the costs of other federal student assistance programs.

The increase in budget authority shown above and in the following tables represents additional interest that accrues to the trust funds because their balances are higher on account of the reduced outlays for benefits.

Phasing Out the Parent's Survivor Benefit. Survivor benefits are paid to the parent (typically, the mother) of children until they reach age 18. If the parent's benefit (but not the children's) was stopped when the youngest dependent turned 16, annual savings would be about $500 million. If the benefit were phased out over three years, the savings in the 1982-1986 period would be nearly $1.7 billion.

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	-1	-5	-27	-67	-112	-212
Outlays	25	90	500	525	535	1,675

NOTE: Preliminary estimates, subject to change.

The case for this change rests on the belief that a single parent whose youngest child is age 16 or 17 is not homebound and can join the work force; in fact, about half of such parents are in the work force. An argument against making this change is that many parents, typically the mothers, have little recent job experience, face problems finding a job in times of high unemployment, and are likely to receive relatively low earnings compared with the family income before the death or disability of the covered spouse.

President Carter proposed phasing out this benefit in his 1980 budget, but the Congress did not act on the proposal.

Phasing Out the Minimum Benefit. The minimum Social Security benefit for new beneficiaries was frozen at $122 per month in 1979. Thus, as earnings rise over time, the minimum benefit will cease to be a factor boosting recipients' benefits over the levels that would result from the application of the regular benefit calculations based solely on past contributions. Eliminating the

minimum benefit immediately would save $65 million in the first year and $790 million over the 1982-1986 period.

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	-2	-10	-22	-44	-56	-134
Outlays	65	135	160	205	225	790

NOTE: Preliminary estimates, subject to change.

The argument for eliminating the minimum benefit is that a significant number of those receiving it are retirees who spent most of their working careers in noncovered employment, typically in government. In fact, about one-fifth of these recipients of the minimum benefit have earned pensions under other programs. The argument against eliminating this benefit immediately is that many of those helped by it are persons who had low earnings, not former government employees receiving a windfall. Elimination of the minimum benefit would increase the demands on the Supplemental Security Income (SSI), food stamps, and other welfare programs, thereby offsetting some of the savings to the Social Security system.

President Carter also proposed phasing out the minimum benefit in his 1980 budget, but the proposal was not enacted.

Phasing Out the Death Benefit. A lump sum death benefit of $255 is paid to surviving families of fully insured workers. Since families do not receive a regular Social Security benefit for a deceased family member for the month in which the death occurred, the lump sum death benefit is the last benefit received for that person. The amount paid is meant to cover part of burial costs, but it normally covers only a small part of them. If the benefit was eliminated and the survivors experienced financial hardship, the SSI or other needs-based assistance programs could be used to provide assistance. Elimination of the death benefit could save over $2 billion in the 1982-1986 period.

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	-15	-46	-80	-118	-159	-418
Outlays	400	410	420	435	450	2,115

NOTE: Preliminary estimates, subject to change.

Aside from the financial hardship that could result, elimination of the death benefit could pose certain administrative difficulties for the Social Security system. The request for the death benefit constitutes one method by which the system learns that a recipient has died, and that regular benefits should be stopped.

Again, in his 1980 budget, President Carter proposed phasing out the lump sum death benefit, but the Congress did not act on the proposal.

REPEAL OF EXTRA PERSONAL EXEMPTION FOR THE ELDERLY

	Annual Revenue Effect (billions of dollars)					Cumulative Five-Year Increase
	1982	1983	1984	1985	1986	
Loss under Current Law	2.5	2.8	3.1	3.4	3.8	
Increase from Repeal of Extra $1,000 Exemption for the Elderly	2.5	2.8	3.1	3.4	3.8	15.6
Increase under Carter Budget	(no proposal)					

NOTE: Preliminary estimates, subject to change.

Under current income tax law, taxpayers 65 or older are allowed an extra $1,000 personal exemption. The extra exemption for the elderly dates back to the Revenue Act of 1948, and was added to take into account the reduction in income usually experienced by those over 65. But the subsidy is paid irrespective of financial need; and, as with all exemptions and exclusions from income, it is worth more in tax savings to those with higher incomes. More than 50 percent of all persons over 65 do not benefit at all from this provision, since their income is so low they would pay no taxes anyway. Of those that do benefit, the 7.4 percent of elderly taxpayers with incomes over $50,000 receive more than 17 percent of the tax relief the extra exemption provides.

Repeal of this extra exemption effective January 1, 1981, would increase federal revenues by $2.5 billion in 1982 and $15.6 billion over the 1982-1986 period. Only about 15 percent of the elderly with incomes below $7,000 would be affected; their average increase in liability would be about $150 in 1982. The average for all those affected would be about $300.

If the Congress wanted to continue providing some tax relief for the elderly, but at a lower cost and in a form more equal for those at different income levels, the present exemption could be converted to a credit. With credits, taxpayers subtract an amount directly from their final tax bill, rather than reducing the amount of income on which the tax is calculated. A credit of $200, for example, would allow all those over 65 to reduce their taxes by

$200. Relative to current law, elderly taxpayers with top marginal tax brackets below 20 percent would gain with such a credit, while those above the 20 percent bracket would lose. Thus, most of the elderly with incomes below about $13,000 would pay less in taxes, while most with incomes above that level would pay more. A $200 credit would raise about $500 million in additional revenue in fiscal year 1982.

DELAY IN SOCIAL SECURITY COST-OF-LIVING ADJUSTMENT

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	-100	-361	-690	-1,062	-1,510	-3,723
Outlays	3,608	4,277	4,735	5,261	5,701	23,582

NOTE: Preliminary estimates, subject to change.

Each July, benefits for the Social Security, Railroad Retirement, Supplemental Security Income (SSI), and veterans' pensions programs are automatically adjusted to reflect increases in the cost of living (COLA). The adjustments are based on the increase in the Consumer Price Index (CPI) from the first calendar quarter of the previous year to the first quarter of the current year. These automatic increases began in 1975, when the federal government's fiscal year started on July 1; now it starts on October 1.

This option would change the date on which the COLA is made from July 1 to October 1, thus shifting the indexation of these benefits to the start of the fiscal year. The computation period for the amount of the COLA would remain as it is in current law.

Enactment of this option would result in large and continuing savings, $4.1 billion in 1981 and nearly $24 billion for the 1982-1986 period if the change was made effective in 1981. The savings in later years would occur because the change would increase the lag after which beneficiaries are compensated for inflation from 15 months to 18 months. This, of course, means that real benefit levels would be reduced for one quarter each year. If the lag were kept as it is now by changing the base period to the second calendar quarter of each year, the fiscal year 1981 savings would still be $ 4.1 billion but the effects in later years are too small to be subject to precise calculation.

The increase in budget authority shown in the table represents the net effect of added interest earned on the higher Social Security and Railroad Retirement trust funds balances and the lower budget authority needed to support benefits in the veterans' pensions and SSI appropriations.

ELIMINATION OF EARNINGS TEST AND TAXATION OF BENEFITS FOR SOME SOCIAL SECURITY RECIPIENTS

	Annual Revenue Effect (billions of dollars)					Cumulative Five-Year Increase
	1982	1983	1984	1985	1986	
Loss under Current Law	13.7	16.4	19.5	23.1	27.3	
Higher Outlays from Liberalization of Earnings Test	0.0	1.8	2.1	2.2	2.2	8.3
Increase from Partial Taxation of Benefits	0.0	2.2	2.8	3.6	4.6	13.2
Net Revenue Increase	0.0	0.4	0.7	1.4	2.4	4.9
Increase under Carter Budget	(no proposal)					

NOTE: Preliminary estimates, subject to change.

Under current law, Social Security recipients below age 72 and their dependents who continue working are penalized for earning more than $5,500 a year by having their monthly cash benefit reduced one dollar for every two dollars earned over the threshold.

The earnings test, as this provision is called, has been a continuing source of controversy since Social Security was enacted in the 1930s. The Social Security Administration has repeatedly resisted attempts to have the test eliminated, arguing that those who remain in the work force have not experienced the income loss that retirement benefits are intended to cushion. But this argument has lost much of its force since the removal of the earnings test for those past 72, and the main objection now is based on the annual cost of about $2 billion that removing the earnings test for recipients above 65 would entail.

The test imposes what amounts to a 50 percent marginal tax on the earnings of Social Security recipients, on top of the 6.65 percent payroll tax and the income tax they must pay on those same earnings. Eliminating this 50 percent tax for those 65 and over would provide such older workers with greater incentives to remain in the labor force, thus increasing payroll tax receipts of the cash-short Old Age and Survivors Insurance (OASI) trust fund, with

a side advantage of reducing the need to provide Supplementary Security Income benefits for some low-income beneficiaries.

The trust fund outlay costs of eliminating the earnings test could be more than offset by taxing half of Social Security benefits, with the tax applying only to those with incomes in excess of $20-25,000, much as unemployment compensation is now taxed. If such a proposal was enacted effective January 1, 1982, it would result in $13.2 billion in additional revenues in the 1982-1986 period. The increase in income tax revenues could be dedicated to the OASI trust fund. The effect would be to replace a 50 percent tax on the earnings of 65- to 72-year-old workers with a lower marginal tax on higher-income Social Security beneficiaries. More recipients would experience an income tax increase than would realize a gain from higher benefits, however. A significant benefit increase for those over 65 would thus be financed with a tax on those beneficiaries who have the greatest ability to pay.

The cash position of the OASI trust fund could be even further strengthened if half of benefits were taxed for all recipients, and the resulting revenues dedicated to the trust fund. Taxing benefits in this way was recommended by the most recent Social Security Advisory Council. Another option would be to tax not half, but all, Social Security income, after the employee's own contributions have been paid back in retirement benefits. Social Security would then be taxed in exactly the same way as private pension payments.

CHANGES IN SOCIAL SECURITY INDEXING

Since 1975, Social Security benefit payments have been adjusted automatically, or indexed, to reflect increases in the cost of living. In recent years, the specific index used to calculate this cost-of-living adjustment, as well as the automatic nature of the adjustment itself, have come under increasing scrutiny. The specific index used is the revised Consumer Price Index (CPI) for urban earners and clerical workers. The CPI has been thought to overstate the actual rise in the cost of living over the past few yars because it reflects an outdated consumption pattern (1972-1973) and because of the manner in which it treats homeownership costs. The first defect causes an upward bias in the index because it does not recognize that consumers adjust their purchases when prices are rising--buying less of goods whose prices have risen most rapidly, and more of substitutes with more slowly rising prices. For example, despite the reduced level of energy consumption brought on by price increases, the CPI still reflects oil consumption levels antedating the OPEC embargo of 1973-1974. In addition, the CPI treatment of homeownership costs exaggerates actual shelter costs because it uses housing purchase prices that reflect not only the cost of shelter but also the investment value of housing. In addition, mortgage interest rates are given inordinant significance in the CPI, a fact that makes the index rather volatile.

The use of automatic indexing has come into question because of the large costs it entails for the federal budget during inflationary periods, and because of the question of fairness that arises when retired workers are given more protection against inflation than those still in the work force. The 14.3 percent cost-of-living adjustment paid in July 1980 will add nearly $17 billion to Social Security outlays in fiscal year 1981 alone. This will be compounded in future years as successive cost-of-living adjustments are calculated on benefit levels that have been increased by previous adjustments.

Using Lower of Wage or Price Index. Several proposals have been advanced for dealing with these problems. One option would be to limit the annual cost-of-living increase to the lower of the rise in the CPI or of a wage index. Wages ordinarily rise faster than prices because of productivity increases. During the 1970s, however, there were two periods (1974-1975 and 1980) when large oil price shocks combined with recessions to make prices rise faster than wages. During these two periods, when the purchasing power of workers declined, Social Security benefits were fully protected through automatic indexing.

Savings from	Annual Savings (millions of dollars) 1982	1983	1984	1985	1986	Cumulative Five-Year Savings
CBO Baseline and Carter Budget						
BA	-211	-529	-916	-1,350	-1,925	-4,931
Outlays	3,815	4,355	5,053	5,643	6,325	25,191

NOTE: Preliminary estimates, subject to change.

If benefit increases were limited to the lower of the rise in wages or of the CPI starting with the adjustment scheduled for July 1981, the estimated savings would total about $26 billion through 1986. Choosing the lower of a wage or a price index would prevent the benefits of retirees from rising faster than the incomes of workers in times of falling real wages. This option, however, would result in lower real benefits for Social Security recipients than under current law. The National Commission on Social Security, which has endorsed this option in its preliminary report, has also proposed that beneficiaries ultimately be compensated for such losses by allowing Social Security benefits to rise by more than the increase in prices when wages are rising faster than prices. Such a catch-up provision would reduce the savings estimated in the table.

The increased budget authority shown above and in the following tables represents additional interest that accrues to the trust funds because their balances are higher on account of the reduced outlays for benefits.

Limiting Increase to 85 Percent of CPI. A second option would be to increase the government's discretion with respect to the automatic cost-of-living increases. One way of doing this would be to follow the procedure now used to adjust white-collar federal pay scales. Each year, after reviewing the nation's budgetary and economic health, the President could propose to the Congress a cost-of-living increase for Social Security not to exceed the rise in the CPI. The recommendation would take effect unless the Congress acted to alter it. If the President and the Congress held the increases in benefits to 85 percent of the expected rise in the CPI starting in July 1981, savings in Social Security outlays over the 1982-1986 period would total about $43 billion. These savings, of course, would represent a substantial erosion of real benefit